

TITLE: IMPROVED ENDOTRACHEAL TUBE SYSTEM AND METHOD OF USE

5 BACKGROUND OF THE INVENTION

The invention relates generally to the field of medical devices. Specifically, the invention relates to an endotracheal tube system that provides for proper placement of the endotracheal tube and for subsequent carbon dioxide detection.

10 A serious problem in the resuscitation of patients is the fast and efficient insertion of an endotracheal tube into a patient and then determining whether the patient is respirating. A medical professional responding to a patient who is not breathing has very little time to react because brain damage occurs after only four minutes without oxygen and brain death occurs at eight minutes without oxygen. Therefore, a need exists to provide the medical professional with an improved endotracheal tube system and method of use which
15 quickly and efficiently places the endotracheal tube within the patient and tests for proper respiration.

Capnography is the term generally associated with monitoring respiration. Capnography specifically is the process of monitoring the concentration of exhaled carbon dioxide in order to assess the physiological status of patients receiving mechanical
20 ventilation and to determine the adequacy of ventilation. It is difficult for the medical professional using a respirator to determine whether the patient is receiving an adequate flow of oxygen without some form of capnography. The medical professional must observe whether the lungs are filling with air or whether the stomach is gurgling because it is filling with air but without some form of capnography the medical professional is not
25 assured whether the patient is receiving an adequate flow of oxygen. For example, the endotracheal tube may be inserted into the patient's esophagus instead of the trachea. Therefore, a need has arisen for an efficient and economical way of determining whether the patient being treated with a resuscitator is actually receiving oxygen.

Carbon dioxide detectors are well known in the prior art for use with an
30 endotracheal tube. However, the prior art carbon dioxide detectors are both cumbersome and time consuming. Moreover, the prior art carbon dioxide detectors are not integral with the endotracheal tubes and therefore create problems when assembling prior to use upon a

patient. Accordingly, an objective of the current invention is an improved endotracheal tube system which incorporates a CO₂ detector directly to an endotracheal tube.

There have been attempts in the prior art to design a resuscitator that integrates a carbon dioxide detector. An example of such a device is disclosed in U.S. Patent No.

5 6,427,687 to Kirk. Unfortunately Kirk is both time consuming and cumbersome because it incorporates a carbon dioxide detector into the resuscitator. Therefore, a medical professional using Kirk must incorporate a disposable CO₂ detector upon the regulator thus requiring an additional step above merely inserting the endotracheal tube into the patient. A further example of a combination carbon dioxide detector and resuscitator is disclosed in
10 U.S. Patent No. 6,584,974 to Ratner. Ratner attaches the CO₂ detector directly to the resuscitator and has the same disadvantages as the Kirk patent. Accordingly, it is an objective of the prior art to incorporate the CO₂ detector in an adapter that may be placed between the endotracheal tube and a bag valve mask.

An additional problem with the resuscitation of patients is the difficulty in placing
15 the endotracheal tube within the trachea. This difficulty is overcome using a metal stylet placed within the endotracheal tube before insertion into the patient. The stylet provides rigidity to the endotracheal tube which provides the medical professional control of the flexible plastic tubing of the endotracheal tube. The stylet is not reusable and must be disposed after every use. The stylet is necessary in emergency situations to assist in
20 manipulating an endotracheal tube through a tracheal tube that is partially collapsed or blocked. The medical professional, because he or she may not know of the problems associated with the trachea, must use the stylet as a default for manipulating the endotracheal tube. Accordingly, an objective of the present invention is to incorporate a stylet into the endotracheal tube system.

25 A still further objective of the present invention is to minimize the amount of pieces and assembly required by medical personnel. With every additional piece that is not preassembled creates increased search time for the pieces, the possibility of dropping the pieces, and the concern for inadequate attachment of multiple parts of the assembled system. Therefore, a further objective of the present invention is to create an improved
30 endotracheal tube system which has all pieces preassembled into a combination such that only a resuscitator or bag valve mask to be attached it.

A still further objective of the present invention is to minimize the amount of time for capnography and subsequent verification of endotracheal tube placement within the trachea as opposed to the esophagus. It is of the utmost concern that no time is wasted for attaching and assembling pieces to the endotracheal tube that could have been
5 preassembled and packaged.

In addition, it is a still further objective of the present invention to produce an improved endotracheal tube system that is sold as a set as opposed to the individual pieces of an endotracheal tube, a CO₂ tube detector, and a stylet. The set can be sold for a reduced price as opposed to the individual prices set for individual pieces.

10 These and other objectives of the present invention will become apparent from the following description of the invention.

SUMMARY OF THE INVENTION

The improved endotracheal tube system utilizes an adapter that is placed between
15 an endotracheal tube and the bag-valve mask. The adapter has a housing having a first tube for attachment to an endotracheal tube and a second tube for attachment to a bag-valve mask. The adapter has a carbon dioxide indicator within the housing that is in gaseous communication with the endotracheal tube but isolated from the outside atmosphere.

The improved endotracheal tube system has an endotracheal tube, an adapter having
20 a housing containing a first tube attached to the endotracheal tube and a second tube for attachment to a bag-valve mask. The system also having a stylet placed within the endotracheal tube and the adapter to provide temporary rigidity to the endotracheal tube. The improved endotracheal tube system may also have a carbon dioxide indicator within the adapter housing. Additionally, the system may have a handle attached to the stylet that
25 facilitates removal of a stylet from the endotracheal tube in the adapter but with handle having seals upon it which prevent the outside atmosphere air interacting with the carbon dioxide indicator.

In the method of the invention, an improved endotracheal tube system is supplied to the medical professional. The medical professional positions an endotracheal tube of the
30 system into a patient. The medical professional will then remove the stylet from the endotracheal tube and the adapter. The medical professional then places a bag-valve mask

upon the adapter and ventilates the patient. One ventilation cycle effectively creates a color change in the carbon dioxide indicator of the system. If the carbon dioxide indicator changes color, the endotracheal tube is correctly placed within the trachea. If the endotracheal tube is not properly placed, no color change will be apparent, vomit or other stomach contents will enter the endotracheal tube, and the endotracheal tube must be discarded.

BRIEF DESCRIPTION OF THE DRAWINGS

Figure 1 is a front view of the improved endotracheal tube system of the present invention.

Figure 2 is an exploded view of the adapter with carbon dioxide detector and a stylet having a handle attached to it.

Figure 3 is a sectional view along line 3-3 of Figure 2.

Figure 3A is an alternate embodiment of the adapter having the carbon dioxide detector held in tracks.

Figure 4 is a picture of the prior art endotracheal tube system with a bag-valve mask attached to it.

Figure 4A is a front view of the adapter of Figure 2.

Figure 5 is the improved endotracheal tube system of the present invention being inserted into a patient.

Figure 6 is the improved endotracheal tube system of the present invention with the handle and stylet removed from the endotracheal tube.

Figure 7 is the improved endotracheal tube system of the present invention with the bag-valve mask attached to the adapter.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENT

Referring now to Figure 1, the improved endotracheal tube system is generally designated by the reference numeral 10. The system has an adapter 12 that attaches to a standard endotracheal tube 14.

The endotracheal tube 14 has a distal end 16 that is positioned within a patient's trachea. The endotracheal tube 14 also has a proximal end 18 in which the adapter 12 is

placed. A standard endotracheal tube has a balloon 20 that is inflated once the endotracheal tube 14 is positioned in the patient. The balloon 20 prevents accidental withdrawal of the endotracheal tube from the trachea and specifically movement past the patient's vocal chords. The balloon 20 is inflated by placing a syringe 22 into the balloon inflating apparatus 24. The standard endotracheal tube may also have medication ports, suction ports, and other ports as disclosed in the prior art.

The adapter 12 has a first tube 26 that fits into the proximal end 18 of the endotracheal tube 14. The first tube 26 may be tapered for insertion into various sizes of endotracheal tube 18. The first tube may be various sizes depending upon the size of the endotracheal tube 18 used. Endotracheal tubes 18 may vary depending on the size and age of the patient. The adapter has a second tube 28 for attachment to a bag-valve mask. The second tube 28 has an outer diameter that may range between 12 millimeters (mm) to 20 mm and preferably has an outside diameter of 14 mm with an inner diameter of 13 mm. The cylinder is preferably 16 mm to 24 mm in length with a preferred length of 18 mm.

On the base of the second tube 28 are six holes equally spaced around the circumference of the second tube 28. The holes 30 measure approximately 3 mm in diameter. As seen in Figure 3, a ring 32 with a C-shaped cross section defining a ring chamber 34 is adapted to be placed over the second tube 28. Inside the ring chamber 34 is placed a carbon dioxide indicator 36. Litmus paper is chemically treated telemetric indicator paper that may be used to detect carbon dioxide. The carbon dioxide detector 36 goes into ring 32. The ring 32 may then be slid over the second tube 28 and positioned against flange 38. The ring 32 is then secured in place. The ring may be secured using adhesive between the interface of the ring 32 and second tube 28 and the ring 32 and flange 38. As seen in Figure 3A, the carbon dioxide detector may be held in tracks 35 of the ring 34.

A stylet 40 is placed within the endotracheal tube 14 and the adapter 12. A stylet provides rigidity to the endotracheal tube when being placed within a user's trachea. The stylet is attached to handle 42. The handle 42 has a plug 44 with seals 46 upon it. The plug 44 and seals 46 create seal upon the adapter 12 so that air cannot come in contact with the CO₂ detecting paper 36. Figure 1 illustrates one seal 46 above the holes 30 and a

second seal 46 below the holes 30. The position of the seals 46 is relevant because the distal end 16 of the endotracheal tube 14 is not sealed.

As seen in Figure 4, the prior art used a cumbersome CO₂ detector having one end 104 that attaches to an endotracheal tube adapter 106. As seen in Figure 4A, the endotracheal tube adapter 106 used in the prior art is of the same general size as the adapter 12 of the present invention but does not utilize any carbon dioxide indicator within the housing of the adapter, in gaseous communication with the endotracheal tube and isolated from the outside air or atmosphere. The CO₂ detector 102 in the prior art also has a second end 108 that is adapted to receive a bag-valve mask 48.

The prior art as seen in Figure 4 has four discreet pieces. The first two pieces being the endotracheal tube 14 with a standard adapter 106. These two pieces are typically supplied together and are sealed in a separate package. The third piece is the CO₂ adapter 102. The CO₂ adapter 102 comes in a separate bag. The fourth piece is the stylet 110 which is a separate piece removed from the endotracheal tube 14 and adapter 102 before placing the CO₂ indicator 102 upon the adapter 102. The bag-valve mask 48 is reusable and therefore not considered as an additional piece. The following table illustrates the number of steps and times associated with using the prior art color CO₂ detector.

TABLE 1: Prior art CO₂ Detector Steps and Times

STEP	PROCEDURE	SECONDS
Step 1	Find endotracheal tube	5-10
Step 2	Open endotracheal tube bag and remove from bag	1-2
Step 3	Find stylet	5-10
Step 4	Open stylet bag	1-2
Step 5	Insert the stylet into endotracheal tube	5-10
Step 6	Find CO ₂ detector	5-10
Step 7	Open CO ₂ detector bag	1-2
Step 8	Utilize Laryngoscope, find trachea, insert endotracheal tube	15-30
Step 9	Fully inflate balloon	4-8
Step 10	Remove stylet	1-2
Step 11	Attach CO ₂ detector	1-2
Step 12	Attach bag to CO ₂ detector	2-4
Step 13	Ventilate	10-15
Step 14	Check for color change	1
Step 15	Remove bag from CO ₂ detector	1-2
Step 16	Remove CO ₂ detector from endotracheal tube	5-15
Step 17	Replace ventilator onto endotracheal tube to ventilate	2-4

As seen in the above table, the best case scenario for emergency medical personnel to insert an endotracheal tube into a person is 64 seconds. The worst case scenario takes much more time. A medical professional is under an extreme amount of stress knowing that in four minutes a person will encounter brain damage and that in eight minutes a person will encounter brain death. Therefore, the medical professional will be experiencing both adrenaline and anxiety. In addition, the medical professional may have problems and find the trachea obscured by the tongue or fatty deposits in the mouth. In addition, the worst case scenario may take much more time because the color change did not indicate that the endotracheal tube was in the larynx and then the medical professional must go back and repeat the steps beginning at Step 1. In addition, the medical professional may accidentally withdraw the adapter 106 from the endotracheal tube 14 when removing the CO₂ detector 102 and then the person will again have to repeat Step 1.

In summary, the best case scenario for the prior art method of detecting CO₂ may range between 64 to 126 second. The worst case scenario may range much longer than two minutes and creep dangerously close to the four minute mark for brain damage and the eight minute mark for brain death. Obviously, with the medical professional also having to encounter delaying issues such as being transported to an accident site on the highway every second matters.

The present invention as seen in Figures 5-7 reduce the amount of steps and time. These reductions decreases the best case scenario time for inserting the endotracheal tube and limits the possibility for error encountered.

TABLE 2: The Present Invention's Steps for Inserting an Endotracheal Tube and Ventilating.

STEP	PROCEDURE	SECONDS
Step 1	Find endotracheal tube system	5-10
Step 2	Open endotracheal tube system bag	1-2
Step 3	Insert Laryngoscope, find trachea, insert endotracheal tube	15-30
Step 4	Fully inflate balloon	4-8
Step 5	Remove stylet plug	1-2
Step 6	Attach bag to adapter with CO ₂ detector	2-4
Step 7	Ventilate	5
Step 8	Check for Color Change	1

As seen in the above table, the best case scenario results in a process which takes between 34 to 62 seconds and reduces the amount of steps from 17 to 8. In addition, the ventilation step is 5 seconds as opposed to 10-15 seconds because this design does not require a filter pad between the litmus paper and the inner surface of the second tube 28 because of the constantly sealed nature of the CO₂ detector using the handle 42. The prior art requires 10-15 seconds because it may require two to three ventilations of the bag as opposed to only one ventilation of the present invention. The present invention also has reduced time because it does not require needless opening of multiple bags but only one bag having the combination within it. The present invention also has a reduced amount of time in a worse case scenario as the CO₂ detector will not be accidentally removed by having the bag valve removed to remove the CO₂ detector.

As a summary of Figures 5-7, the medical provider first inserts the improved endotracheal tube system into a patient using a Laryngoscope 50. As seen in Figure 6, the medical provider then inflates the balloon 20 using a syringe 22 attached to opening 24. The user can then withdraw the handle 42 from the adapter 12 thus pulling the stylet 40 from the endotracheal tube in the adapter. As in Figure 7, the user then attaches the bag-valve mask or ventilator 48 and compresses the bag to press air into the patient's lungs. The medical provider then permits the bag-valve mask to pull gas from the patient and if it is properly placed on the larynx, it will pull CO₂ rich gas from the user's lungs and pass it through the CO₂ detector and the adapter 12. If there is no color change, the medical provider will remove the endotracheal tube 14 from the patient and replace with a fresh tube. If the endotracheal tube is in the larynx, the medical provider will continue to respiration the patient.

The invention has been shown and described above with the preferred embodiments, and it is to be understood that many modifications, substitutions, and additions may be made which are within the intended spirit and scope of the invention. From the foregoing, it can be seen that the present invention accomplishes at least all of its stated objectives.